RYAN WHITE ADAP TECHNICAL ASSISTANCE CONFERENCE CALL

?ADAPS AND CORRECTIONAL FACILITIES: ENSURING A CONTINUUM OF CARE?

Held March 17, 1999 4:00PM - 5:00 PM EASTERN TIME

Arranged jointly by:
Division of Service Systems
Health Resources and Service Administration
and
National Alliance of State and Territorial AIDS Directors

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EXECUTIVE SUMMARY

Introduction

This report summarizes the information presented in "ADAPs and Correctional Facilities: Ensuring a Continuum of Care," the seventeenth in a series of nationally broadcast technical assistance telephone conference calls focusing on State operated AIDS Drug Assistance Programs (ADAPs), which was broadcast on Wednesday, March 17th, 1999. This ADAP teleconference series was arranged by the Division of Service Systems (DSS), Health Resources and Services Administration (HRSA), in collaboration with the National Alliance of State and Territorial AIDS Directors (NASTAD).

The teleconference began with statements from DSS and NASTAD staff regarding current issues of importance to grantees. Summaries of these statements are found in Appendix I. Following these statements, call faculty (from HRSA and from the States) presented the teleconference topic. A question and answer (Q & A) session with call faculty and listeners followed the grantee presentations. A list of teleconference faculty is presented in Appendix II. Basic information describing the presenting State ADAPs is found in Appendix III.

Teleconference Topic: ADAPs and Correctional Facilities: Ensuring a Continuum of Care

Massachusetts: Continuity of Care for County Jail and House of Corrections' Populations

In many States, the county jail and house of corrections' populations have not been prioritized because of the inmates' short period of incarceration. In 1994, the Massachusetts Department of Health conducted a needs assessment and developed a comprehensive strategy to meet the needs of this population. Inmates in the jails and houses of corrections are able to participate in the State ADAP program while incarcerated. This program is funded entirely with State dollars. The Massachusetts program focuses on prevention, education, counseling and testing, and HIV treatment.

Nevada: Program Development for Incarcerated Populations

A sequence of planned steps led to the implementation of a standardized continuity of care for the incarcerated population in Nevada. The key element is fortified relationships with those in the criminal justice system. The prison is responsible for completing the ADAP application and making appointments at the community HIV clinics, within 30 days prior to an inmate's release. The ADAP provides a 30-day supply of medication for inmates on discharge. Outcome evaluation studies show that inmates are following up with appointments and remaining on ADAP. HIV testing and names reporting is mandated in the prison. Nevada has the ability to monitor the recidivism rate of inmates being discharged, which over time, makes a solid case for discharge planning.

I. TELECONFERENCE PRESENTATIONS:

ADAPS AND CORRECTIONAL FACILITIES: ENSURING A CONTINUUM OF CARE

Tim Gagnon

Coordinator of Jail and Prison HIV Programs, Massachusetts Department of Public Health

Inmates in county jails and houses of correction are a very different population than those in the State prisons. These inmates are incarcerated for very short periods of time and have a high level of interaction with local communities. Quite often the health care infrastructures at these jails and houses of corrections are not equipped to handle complicated medical conditions, particularly HIV. Nationally, there are approximately fifteen to twenty inmates who pass through local houses of correction for every one inmate that is incarcerated in a State prison. These inmates, however, do not usually receive the level of care and services comparable to their counterparts in the State prison. Five years ago, the Massachusetts Department of Health conducted a needs assessment and developed a comprehensive program to meet the needs of this population. One of the features of the program is that inmates in these jails and houses of correction are able to participate in the State ADAP program while incarcerated. This program is funded with State dollars. Federal ADAP dollars are prohibited from providing treatment for incarcerated individuals. Some inmates are enrolled in ADAP prior to being incarcerated, and as a result of this program, the majority of HIV-positive inmates are enrolled at the time of release. The Massachusetts program focuses on prevention, education, counseling and testing, and HIV treatment. The ADAP case load has increased from less than 200 in 1994 to over 1,500 inmates in the county jail systems now receiving treatment for HIV.

In many States, this particular population has not been prioritized because of their short period of incarceration; however, this is a critical public health opportunity to provide counseling, testing, education, and treatment. Many of these inmates who move on to the State prison system are clinically stable and able to continue without treatment interruption. The HIV-related morbidity in the communities where these facilities exist has been significantly reduced. This program ultimately enhances patient adherence to medication and the continuity of care and treatment for people living with HIV/AIDS.

Richard Whitley

Title II Coordinator Nevada State Health Division

Background Information:

There are 9,200 inmates incarcerated in the Nevada Department of Prisons. Currently there are 154 inmates incarcerated who are HIV infected. Nevada has had mandatory HIV testing at the time of incarceration and prior to release since 1986.

Public health and public safety programs and services for criminal offenders are often complicated by gaps between the two systems. Other problems often presented by incarcerated individuals

such as mental illness, substance abuse, dual diagnosis and personality disorders, further complicate care. A sequence of planned steps led to the ultimate success in the implementation of standardized continuity of HIV care for the incarcerated population in Nevada.

Nevada's program was initiated in 1998, following a combined prevention and care Statewide HIV/AIDS needs assessment that included data from both the jails and State prison system. Surveys, focus groups, and interviews were conducted with inmates and facility service providers, as well as clinic and community service providers that typically see inmates after discharge from prison. As a result, the Ryan White Title II Care and Service Planning Council gained membership representation from people living with HIV who had previously been incarcerated. The Planning Council made discharge planning for inmates a priority service need. Meetings were held with the Director of Prisons and the Director of Prison Medical Services in order to obtain their support and permission before proceeding.

The critical elements of the Nevada program are the strong relationships built between public health staff and criminal justice system staff. Acknowledging that one will only be able to access this unique community through cooperation with the figurative, as well as literal, gatekeepers of this system is of critical importance. The Director of Prisons and the Medical Services Director, because of the continuity of care and the community linkage elements, approved ADAP coordination with the Department of Prisons.

Next, memorandums of agreement were developed in order to clarify roles and responsibilities between the agencies. The prison is responsible for completing the ADAP application and making appointments at the community HIV clinics 30 days prior to the inmate's release. The ADAP provides a 30-day supply of medication for inmates on discharge. Implementation of the discharge planning process was initially difficult, because the county jail really is its own system with a warden, custody staff, institutional physicians and a director of nursing. Policies, as established in the memorandum of agreement, do not always translate into congruent procedures. In order to achieve actual implementation, a team consisting of the State ADAP coordinator, the ADAP pharmacist, an HIV clinic nurse case manager and a staff member from the lead community-based organization toured each facility, meet with staff and established actual institutional operational procedures.

The Health Department sponsored a series of meetings with representation from all interested parties: the Departments of Prisons and Parole, community HIV clinics, jails, community-based organizations and former inmates. Ryan White staff essentially became facilitators to a group process during our first meeting. During the meeting, it became clear that there was a previously unmet need for these agencies to be brought together. Since this first meeting, there has been an increase in collaboration between agencies. The prison Medical Director recently became a member of the State AIDS task force; a physician from the prison is a member of the ADAP physicians' advisory committee, and prison staff attend prevention and care workshops and conferences.

Outcome evaluation studies have shown that inmates are following up with appointments and remaining on ADAP. In the four months of monitoring this project, nine inmates have left prison

with discharge plans and uninterrupted enrollment in ADAP. Nevada's efforts are maintained by a team made up of the ADAP coordinator, the prison pharmacist, nurse, case manager and a member from the lead community based organization. These individuals participate in monthly HIV support groups at each facility to explain to inmates and staff what services exist and how to access them.

II. SUMMARY OF Q AND A SESSION:

A registrant from Alaska asked if the presenters had any advice on ADAP clients who move in and out of the correctional system. Tim Gagnon responded that most movement of inmates occurs in the county jails. In Massachusetts, because there is a continuum of ADAP care, there is no break in treatment. The Massachusetts program has several caseworkers assigned at each facility to help with discharge planning. Celia Banda-Brown added that California has centralized their ADAP through a Pharmacy Benefits Manager (PBM), which has allowed jails to have confidential on-line access to the State's PBM database for ADAP clients who become incarcerated. Participating jails can then verify which therapies are needed by incoming inmates.

A participant from Oregon asked if individuals awaiting trial in county jail systems are eligible for ADAP services. John Palenicek responded that *State funds*, not Federal funds, may be used to support specific services or therapeutics for incarcerated populations, so long as they do not supplant other State or Federal funds.

A caller from New York asked about the source of medications for incarcerated individuals. Different jails have different procurement systems for supplying pharmaceuticals to their prisoners. The reimbursement process of the jail pharmacy is often the same as it is for any neighborhood pharmacy.

A registrant from Georgia requested clarification regarding ADAP funds being used to fund drugs for inmates. John Palenicek answered that no Federal ADAP dollars can be used for the payment of therapies for incarcerated individuals.

A caller from Colorado asked if there were any suggestions on assisting small county jails in purchasing and supplying medications on short notice. Celia Banda-Brown responded that some county jails have arrangements with local retail pharmacies to supply drugs to the jail pharmacy. Tim Gagnon added that Massachusetts recommends that all jails maintain an inventory of the more common HIV medications.

A participant from Oregon asked about the practicality of enrolling county jail inmates on ADAP, given their short stays. Tim Gagnon answered that discharge planning begins on the first day of incarceration. A Massachusetts caseworker refers inmates to an ADAP-participating pharmacy in their neighborhood upon release. The inmate's ADAP eligibility remains intact for some months after release. The normal reapplication period will then begin for clients who gain insurance coverage following their release from jail. Richard Whitley added that Nevada has memorandums of understanding between the sites through which the inmates pass to afford a greater level of collaboration and coordination of care.

APPENDIX I

DSS/NASTAD UPDATES

DSS Statement

Annette Byrne

- It has come to HRSA's attention that certain manufacturers, such as Glaxo-Welcome, have encouraged ADAPs to maintain their original contracts, regardless of participation in the new Section 340B rebate option. If you have any further questions on this issue please feel free to call HAB staff.
- To date, HAB has only received one request from a State for the use of Title II ADAP funds to purchase insurance. Other States that are interested in this must send information to the Grants Management Office. HRSA also requires that the methodology to document cost neutrality is provided and that the insurance policy includes, at a minimum, the drugs on the state formulary. Please send in your requests as soon as possible.
- HRSA has reviewed the Title II applications and there seem to be some discrepancies in the way certain drugs have been counted. As a result, the numbers of drugs that are listed in your formulary in the application are not the same as those reported on the State profile. There may also be discrepancies about how to count certain forms of drugs, such as Fortovase, which is another form of saquinavir, and combivir, which is a combination of AZT and 3TC. For accuracy purposes, please note that HRSA is counting saquinavir as one drug in two forms and combivir as one drug.
- HRSA will shortly be sending out the standard AMR reports. HRSA is very interested in receiving feedback about these reports. Please feel free to call Paul Mahanna directly at 301-443-4063 with any questions or comments.
- Title II awards will be sent out at the end of March.
- The Ryan White Title II/ADAP National Meeting is scheduled for May 23 and 24 in Washington, DC.

NASTAD Statement

Arnie Doyle

- The National ADAP Monitoring Project Annual Report, also known as the Kaiser Report, was released at a press briefing in Washington, DC on March 9.
- PAREXEL, formerly Rescon, hosted the Southeastern Regional ADAP Conference on March 10-12 in Atlanta. The meeting was cosponsored by NASTAD and TII-CANN and was funded with the generous support of several pharmaceutical manufacturers. The meeting brought together State AIDS directors, ADAP, Title II program staff, and State and regional Medicaid staff for an intense two-day meeting. This conference was extremely successful from the perspective of the State AIDS programs and from the perspective of the Medicaid programs.

There are tentative plans to hold a similar regional meeting for the mountain States in the coming year.

• NASTAD is continuing internal discussions with the States on reauthorization of the CARE Act. Reauthorization is going to be one of the major topics of the upcoming NASTAD annual meeting on April 18-21.

APPENDIX II

TELECONFERENCE PARTICIPANTS

From the Division of Service Systems, Health Resources and Services Administration

Annette Byrne, ADAP Branch Chief, Acting Deputy Director, DSS
John Palenicek, Director of Policy and Program Development, HIV/AIDS Bureau (HAB)
Doug Morgan, Director, DSS
Erica Buehrens, Consultant/Moderator, DSS
Bridgette Patterson, Program Analyst, DSS
Tracy Carson, Consultant, DSS
Jesse Glidewell, Senior Public Health Analyst, DSS

From the National Alliance of State and Territorial AIDS Directors (NASTAD)

Arnie Doyle, Research Associate Sasha Schamber, Program Associate

State Grantee Presenters/Participants

Tim Gagnon, Coordinator of Jail and Prison HIV Programs, Massachusetts Department of Public Health

Richard Whitley, Title II Coordinator, Nevada State Health Division Celia Banda-Brown, ADAP Health Program Specialist, California Department of Health Mary Marinelli, Office of AIDS/STD, Rhode Island Department of Human Resources

APPENDIX III

PRESENTING STATE INFORMATION

ADAP CONFERENCE CALL

Wednesday, March 17, 4PM EST

"ADAPs and Correctional Facilities: Ensuring a Continuum of Care"

Massachusetts: Tim Gagnon, Coordinator of Jail and Prison HIV Programs, Massachusetts Department of Health

Number of Enrolled Clients: 200
Average Monthly Users: 800
% of Clients receiving PI's: 90%

 Total FY 98 ADAP Funds:
 \$11,213,213

 State Contribution:
 \$2,000,000

Title I Contribution: \$0 ADAP Formulary: 35

Eligibility Criteria: 400% FPL; HIV + diagnosis

Current Restrictions: None

Cost-Saving Strategies: Enrolled in Section 340B Rebate Option

Statewide ADAP Advisory Body: Yes

Presentation highlights:

• A focus on county jails/houses of correction, institutions with short sentences and high turnaround.

- ♦ The Massachusetts Department of Health's use of State dollars to provide therapeutics to incarcerated individuals in these institutions.
- ♦ Wide range of benefits of providing this assistance, including primary care access, uninterrupted treatment care, & patient adherence.

Nevada: Richard Whitley, Title II Coordinator, Nevada State Health Division

Number of Enrolled Clients: 453
Average Monthly Users: 453
% of Clients receiving PI's: 68%

 Total FY 98 ADAP Funds:
 \$4,279,595

 State Contribution:
 \$1,200,000

Title I Contribution: \$0
ADAP Formulary: 19

Eligibility Criteria: 200% FPL; HIV + diagnosis

Current Restrictions: None

Cost-Saving Strategies: ODP Participating

Statewide ADAP Advisory Body: Yes

Presentation highlights:

- ♦ Internal Ryan White Coordination within the State.
- ♦ Importance of a Memorandum of Agreement, in the context of Prison Policy/Procedures/ADAP Policy/Procedures.
- ♦ Identified coordinators within the community (HIV/AIDS clinics-case managers, CBO lead agencies)
- Ensuring a continuity of treatment/care through a 30 days supply of medication available upon exit / appointment at community medical clinic within 30 days of discharge.

^{*}As projected for FY 1999 in the Title II FY 1999 Application for Federal Assistance

Nevada State Health Division's HIV/AIDS Program

STEPS TAKEN TO DEVELOP CONTINUITY OF HIV/AIDS CARE FOR THE INCARCERATED POPULATION

- 1) COORDINATION WITHIN OUR OWN SYSTEMS:
 - State Health Division
 - •HIV/AIDS PROGRAM (between Prevention, Surveillance, and Care Services)
 Priority setting based on negotiation and compromise
 - Ryan White Title II Care and Services Planning Council Priority setting and funding allocation
 - Coalitions and Consortia

Explanation and clear understanding of approach

2) ESTABLISHING AND BUILDING THE RELATIONSHIPS

Statewide meetings: networking, linking, and identifying gaps/barriers

- 3) STRATEGIC PLANNING
 - Ethics
 - Vision
 - Mission
 - Goals and Objectives
 - Plan
 - Time line
 - Evaluation
- 4) MEMORANUMS OF AGREEMENT
- 5) PRISON POLICY/PROCEDURES
- 6) ADAP POLICY/PROCEDURES
- 7) IDENTIFIED COORDINATORS WITHIN PRISON SYSTEM
 - Social Workers regionally
 - Registered Nurse at each facility
 - Pharmacist

8) IDENTIFIED COORDINATORS WITHIN THE COMMUNITY

(HIV/AIDS Clinics---case managers, CBO lead agency)

- 9) DISCHARGE PLAN includes:
 - ADAP Application completed/30 days supply of medication available upon exit
 - Appointment at community medical clinic within 30 days of discharge
 - ullet Review for eligibility and referral to community-based services (housing, mental health & substance abuse services, transportation), welfare, disability benefits.

